Recently graduated midwives in Uganda: Self-perceived achievement, wellbeing and work prospects

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Introduction

There are currently over 2.5 million pregnancies a year in Uganda, and this is predicted to rise to 3.4 million by 2030 (UNFPA 2017). Almost half of the population is aged 15 or younger, the teenage birth rate stands at 140 per 1000 adolescent girls, and the fertility rate is nearly six births per woman (WHO 2018a). The maternal mortality rate has been falling but is still extremely high - 343 deaths per 100,000 live births. WHO (2018b) estimates that a skilled birth attendant is present at 74.2% of births but supporting them are only 0.648 nurses and midwives per 1,000 population, and 0.35 obstetricians and gynaecologists per 100,000 women of reproductive age. In addition to human resource shortages Sharma et al. (2015) also identify lack of finance and weak service delivery as features of the health system in Uganda along with other low income countries.

In this context, midwives are unable to meet much of the need for their services, especially in rural areas (World Bank 2017). They experience long hours, low remuneration, poor working conditions, shortage of equipment and supplies, and limited opportunities for professional and career growth . The education system for training and supporting midwives is also small and of variable quality, with standards widely falling below those set out by the World Health Organisation (WHO 2016). Opportunities for midwives to upgrade their professional training are further constrained by lack of finance and by pressure to continue to work to support their families (Nabirye et al 2011).

Since 2000, the Aga Khan School of Nursing and Midwifery in East Africa (AKU SONAM EA) has offered a work/study programme to help registered nurses top up their qualifications to degree level, whilst continuing to work in their clinical areas, and in 2015 this approach was offered for the first time to registered midwives in Uganda (Edwards et 2018). The first

cohort of 15 midwives successfully graduated in 2018. The programme is offered over five semesters (two and a half years) with each semester lasting 18 weeks. Students attend the university for two days a week, which enables them to study on their days off if they are unable to secure study leave from their employers – an important educational access issue in many low and middle income countries (LMIC). The programme is balanced between theory and practice and exceeds the benchmarks laid down by the International Confederation of Midwives (ICM 2010).

Research into students' and graduates' experience of work/study programmes can serve an important role in improving their quality and effectiveness, but is limited and set in very different contexts (e.g., Wallace, 2016), Brownie et al. (2018) report that a nursing work/study programme in East Africa was an effective tool in building a sustainable and effective nursing workforce. However, other research suggests that the challenges of working and studying at the same time can have negative effects on the personal and professional lives of participants, including contributing to financial stress (Martinez et al. 2013). These findings suggest that the effect of such programmes depends not only on curriculum quality and technical learning outcomes, but also how they affect students' wider wellbeing and future prospects. Since this was the first time a BScM was offered as a work study programme, its promoters attached a high priority to conducting research into the experience, broadly defined, of the first cohort of students. The endeavour was part of the provider's commitment to continuous measurement and evaluation of programme offerings within the school.

To do so, the research adopted a holistic and qualitative approach, recognising the potential for education to affect distinct domains of students' wellbeing, to raise their aspirations and to pose new challenges across multiple domains (Copestake and Camfield, 2010). The research was informed both by the WHO (1995) definition of quality of life as: "the perception that an individual has of his or her place in life, within the context of the culture and system values in which he or she lives, and in relation to the objectives, expectations, standards and concerns of this individual," and more specifically by an appreciation of the importance to their wellbeing of students' and graduates' social relationships with their peers (White, 2018). The study was also methodologically innovative, being only the second example of use of the Qualitative Impact Protocol (QuIP) to research drivers of change in the wellbeing of students enrolled on an educational programme (Morsink et al. 2019). A full version of the report on which this paper is based is available from the lead author.

This paper reports on a qualitative enquiry into perceptions of wellbeing and work prospects of members of the first cohort of AKU SONAM EA graduates in midwifery in Uganda. It first sets out the methodology employed, then provides a summary of key findings and concludes by emphasising the need for such programmes to address social as well as technical skills required for career development, including leadership capacity and resilience in handling working relationships.

Methods

Objectives

The overall aim of the research was to investigate how recent graduates from a combined work/study midwifery degree programme in Uganda viewed its effects on their wellbeing and work prospects. This was broken down into three objectives:

1. To investigate changes in selected wellbeing domains of the new graduates, in relation to their diverse, multiple and changing aspirations.
2. To assess the contribution to these changes in their wellbeing of their recently completed study.
3. To provide feedback on the benefits and challenges of the programme to its providers and other stakeholders.

Standards for data analysis and reporting

Quality assessment was made using the Standards for Reporting Qualitative Research (SRQR) appraisal tool, see supplementary file 1.

Ethical approval

Ethical approval was obtained from the AKU SONAM EA review committee and the Uganda National Council for Science and Technology (approval number T-REC 13/18).

Participants

Participants were the first cohort of graduates from the AKU midwifery degree programme in Uganda comprising 15 students, one could not be contacted but the other 14 all consented to participate in the study, ten of whom were based in Kampala.

Qualitative Impact Protocol (QuIP)

The research utilised the *Qualitative Impact Protocol* (QuIP), an approach to impact evaluation based on collecting narrative evidence of causal drivers of change in specified domains directly from the intended beneficiaries of the evaluand (Copestake 2014; Remnant and Copestake 2019). Semi-structured interviewing was used to allow respondents to share their experiences of change over a predetermined time period openly with an independent researcher. The QuIP was designed particularly for use in complex contexts where there are diverse and uncertain possible effects of an intervention, whose influence is hard to disentangle from many other factors. It had been utilised in a wide range of settings (Mager et al. 2017; Copestake et al. 2018; Tearfund 2018; Copestake et al. 2019), including once previously for evaluation of a health education intervention (Morsink et al. 2019).

An innovative feature of the QuIP is to limit how much respondents and interviewers are informed of the intervention being assessed in order to mitigate the risk of confirmation bias (Copestake et al. 2018). In this research all those involved were fully informed of the ultimate aim of the study. However, the semi-structured questionnaire did not refer directly to the midwifery programme. Instead questions were framed by first identifying changes in specified wellbeing domains and then exploring possible causes of these changes in an open-ended way. A range of theories of well-being could have been utilised to determine the domain structure for interviewing and data analysis (e.g. see Gough and McGregor, 2007). Instead, the domains were agreed through discussion and deliberation with the educational provider and commissioner of the research, in order to reflect what they perceived to be most relevant to understanding the impact of the programme.

Data Collection

A draft of the semi-structured questionnaire was first piloted with a sample of midwives from a separate cohort. This structured interviews around seven domains: work roles; professional skills; confidence in their role; professional relationships; personal relationships; wellbeing; career prospects and aspirations for the future. Each domain was introduced by an open-ended question inviting respondents to specify the main changes they had experiences in this domain during the past two years. Discussion of each domain concluded with a closed question asking respondents to sum up whether their overall experience of change in this

domain over the two years had been positive, negative, neutral or unclear. Table 1 reproduces the open and closed questions for each domain.

Table 1. Open and closed questions by domain

Domain	Open-ended generative questions	Concluding closed questions
Workplace roles	In the last two years, how has your day-to-day work changed?	In the last two years, how has your role in the workplace changed overall? *[Improved/No change/Worse/Not sure]*
Skills	Do you feel there have been any significant changes in your ability successfully to perform your duties?	How has your professional ability/skills changed overall? *[Better/Same/Worse/Not sure]*
Confidence in role	Has anything changed in terms of your confidence to undertake your day-to-day work?	How has your confidence to undertake your day-to-day role changed overall? *[Increased/Same/Worse/Not sure]*
Professional relationships	How have your relationships with work colleagues changed, if at all?	Overall, how have your professional relationships changed? *[Better/The same/ Worse/ Not sure]*
Personal relationships	How have your relationships with friends and peers changed, if at all?	Overall, how have your relationships with friends and peers changed? *[Better/The same/Worse/ Not sure]*
	How have your relationships with family members changed, if at all?	Overall, how have your relationships with family members changed? *[Better/The same/ Worse/ Not sure]*
Wellbeing	Have there been changes in your living conditions? Has anything changed in relation to your work/life balance? How have your anxiety and stress levels changed, if at all? How have your mechanisms for dealing with traumatic experiences in the workplace changed, if at all?	Overall, taking all things into account, how do you think your well-being has changed? *[Improved/Same /Worse/Not sure]*
Career prospects &	Looking back over the last two years, do you feel that your career opportunities have changed?	Overall, how do you think your career opportunities have

aspirations for future	Looking ahead, do you feel different about your future career opportunities than you did?	changed? *[Better/Same/Worse/Not sure?]*

Note: All questions also explicitly referred to changes in the last two years. Interviewers were also provided with more detailed probing questions they could use in relation to each domain to deepen responses to the generative questions.

All interviews were conducted in English, audio-recorded and transcribed in first person annotated format. On completing them the researcher team invited the respondents to join a *WhatsApp* group through which they could continue to discuss the findings of the interview together over a three week period. The *WhatsApp* group was comprised of the 14 midwives and two field researchers to give the graduates a platform to share experiences, best practices, successes and challenges related to their daily personal and professional life, and to encourage networking and support between the midwives. This group also allowed the research team to gain more insight into the daily experiences of the midwives and inform the future content of the midwifery curriculum. Triangulating these findings against those from individual interviews also helped to explore how (far) the self-perceived wellbeing of the students was co-produced within peer groups. This approach was also relatively easy to implement because the midwives had already established their own *What'sApp* group as students to provide additional support and communication for each other when they were back in their own clinical areas.

An independent researcher then analysed the full transcript of these discussions alongside typed summaries of the individual interviews. One set of thematic codes identified the main positive and negative wellbeing changes reported by respondents, and a second set covered reported causal drivers of these changes. Drivers were also coded according to whether coded causal statements *explicitly* linked outcomes to the midwifery training.

Results

A total of 14 respondents participated out of the total group size of 15. For anonymity, the participants were grouped as under 35 years and over 35 years of age. The demographics of the cohort are shown in Table 2.

Table 2. Demographic details of the participants

Respondent	Years of practice prior to study	Distance to study	Age	Area of Practice	No of Children
1	+ 9 years	+ 20 km	< 35	Rural	1
2	+ 9 years	+ 20 km	< 35	Rural	3

3	+ 9 years	+ 20 km	< 35	Urban	3
4	+ 9 years	- 20 km	< 35	Rural	4
5	+ 9 years	- 20 km	< 35	Urban	3
6	+ 9 years	- 20 km	< 35	Urban	2
7	+ 9 years	- 20 km	< 35	Urban	3
8	+ 9 years	- 20 km	< 35	Urban	2
9	- 9 years	+ 20 km	> 35	Rural	0
10	- 9 years	+ 20 km	> 35	Rural	0
11	- 9 years	- 20 km	> 35	Urban	1
12	- 9 years	- 20 km	> 35	Rural	1
13	- 9 years	- 20 km	> 35	Urban	2
14	- 9 years	- 20 km	> 35	Urban	1

Closed question responses

The 14 respondents' responses to the 8 closed questions listed in the last column of Table 1 were overwhelmingly positive (108 out of 112), while three reported no change and only one described overall change in a domain as having been negative - with respect to relationships with friends and peers. Respondents most often attributed the positive changes they had experienced in the previous two years either explicitly or implicitly to their midwifery programme (see Table 3). The two most frequently used driver-of-change codes were "graduating with a degree from AKU" (used for all 14 respondents, and on average across 6 domains), and "receiving training from AKU" (used for 13 respondents, and on average across 5 domains). It is likely that the prevalence of these explanations partly reflects some confirmation bias, given that respondents knew that the purpose of the study was to assess the AKU midwifery programme. But the possibility of some positive confirmation bias also adds to the potential significance of the smaller number of negative outcomes explicitly or implicitly attributed to the programme.

Table 3. Frequency counts of attribution coding by category

Normative assessment of the outcome:	Positive	Negative
Explicitly attributed to the AKU midwifery degree programme or to linked activities.	94 (47%)	8 (4%)
Implicitly confirming (positive) or challenging (negative) the programme's theory of change, but without explicit reference to it.	40 (20%)	23 (12%)
Attributed to incidental causes, unrelated to the programme's theory of change.	15 (8%)	18 (9%)
Total number of coded causal claims, across 14 interviews and all 7 domains.	198 (100%)	

Coding of responses to the open-ended questions revealed a wide range of positive outcomes, many of which respondents reiterated at several points through their interview (see Table 4). Most frequently cited were increased knowledge and skills. Repeated references to ability to perform work duties, improved quality of patient care, and patient centred care are also indicative of enhanced technical and professional competence. The respondents also made numerous references to improved social and communication skills, confidence, professional commitment and career aspirations. Eight of the midwives also reported obtaining a more senior and/or better paid job after graduation.

Table 4. Reported positive outcomes.

Positive Outcome	Respondents referring to the outcome	References per respondent
Increased knowledge and skills	14	5.8
Increased confidence/self-worth	14	3.4
Improved ability to perform work duties	14	2.9
Improved communication skills	12	2.3
Improved quality of patient care	13	2.2
Colleagues consult graduate midwife for advice/mentoring	13	1.9
Practice patient centred care	10	2.2
Higher career aspirations	14	1.6
Improved working relationships with colleagues	12	1.8
Peer support for discussing work situations	12	1.8
More confidence interacting with colleagues	11	1.9
More career opportunities	12	1.7
Deeper commitment to midwifery	9	2.1
Obtained job promotion	8	2.4

Note. References per respondent indicates the mean number of domains across which respondents mentioned an outcome (for only those who referred to it).

The negative outcomes most often mentioned by respondents were that their colleagues felt threatened by their new status, and were resentful towards them, and that they experienced an increase in workload (e.g. spending less time at home, trying to hold down two jobs (see Table 5). These problems were often attributed to their graduate training, including debts incurred financing it. But they were also hedged by many positive statements about how the programme had strengthened their knowledge, social skills and confidence to cope with the demands put upon them.

Table 5. Reported negative outcomes.

Negative outcome	Respondents referring to the outcome	References per respondent
Co-workers feel threatened by graduates	10	1.2
Resentment from colleagues	10	1.1
Increased workload	10	1.0
Unable to treat patients effectively	5	1.4
Spending less time at home	6	1.0
Trying to hold down two jobs	4	1.0
Increased levels of stress	3	1.0
Increased competition for jobs	3	1.0
No increase in salary despite qualification	3	1.0
Unable to apply for other jobs or further study	3	1.0
Increased pressure to earn more	2	1.5

Note. References per respondent indicates the mean number of domains across which respondents mentioned an outcome (for only those who referred to it).

Thematic analysis of open ended questions

Syntheses findings was undertaken across discrete domains with responses thematically coded in keeping with the thematic analysis of qualitative data (Braun and Clarke, 2006). Analysis highlighted and illustrated four overarching themes. . These are: improved technical knowledge and professional skills arising from the AKU programme; increased professional confidence and assertiveness; more stress and work pressure, but also capacity to cope with this; and raised career aspirations. Quotations in italics are taken from interview and *WhatsApp* transcripts.

Improved technical knowledge and professional skills

Respondents provided many specific examples of knowing what to do, including thinking for themselves and following evidence-based practice. They also emphasised the value of support in practicing new clinical procedures, rather than just being taught about them.

> *In midwifery you do what you know. Since I have the skills that I got from the University, I am able to perform my duties in my role. Before we would just do what you are told but now we practice evidence-based midwifery (r4).*
>
> *In the clinical practice I now use evidence-based interventions… it means that I know what to do and why I do it, I have practiced it and it has worked out. I can confidently identify a condition and decide on what to do (r8).*

I have managerial skills and attitude, I am willing to work and I supervise myself. When I am on duty I make programs for all units and make sure they have all the basic things they need for infection control and supervise and see all those things are in place and I take action (r9).

Increased professional confidence and assertiveness

All the respondents reported being more confident in clinical decision-making, and assertive with colleagues (including doctors) in clinical settings.

Now I am capable of presenting; I presented in Nairobi in a midwives' symposium my abstract which I developed in Aga Khan, without shaking, but before when I was told to present even in front of my classmates the confidence would go down and I would shake… Now I can interact with doctors, I can interact with the in-charge and I can say no in the management of some cases if am not satisfied with the procedures that they are taking (r14).

Before joining Aga Khan University I could not challenge a doctor's opinion even when I felt it was questionable, but now I make my opinion known (r10).

An example of where I am more confident in my work was when a mother came who had pre-eclampsia and the doctor decided to do a C-section but I told him no because we had no facilities for premature births, and on top of that the mother was still in the stage of monitoring - stage A. When the doctor refused to agree I brought him the manuals and proved to him. She was at 32 weeks, the blood pressure well controlled so I stood firmly and told the doctor no. The second scenario was with the shoulder dystocia when a doctor was called he said that you arrange for a C-section so what I did was to transform what I was taught at Aga Khan, I did it and the mother delivered. The doctor said the mother had her complications and that I forced her to push. I just told him that there are other mechanisms that we follow and the baby comes out, we monitored her for three days and the mother was okay (r3).

Increased work pressure, stress and resilience

Many respondents reported how feeling more competent and being more assertive earned them the respect of both clients and colleagues. But it also had two negative repercussions: exacerbating resentment and jealousy and leading to being given even more work to do in contexts where resources were already severely stretched.

I have not had any problem with anybody except a few who think when we went for bachelor's we are going to take their positions. There are those that are envying us because we have managed to attain that qualification (r8)

When I completed my bachelor's degree I think my supervisor thought I had become a threat to her. She kept saying that I was doing whatever I could do to undermine her because I had a degree (r9)

They look at you as a threat for example if you bring in something new, some will say is it because you have a degree? (r3)

If you become a preferred midwife and all praises are heaped on you, colleagues can withdraw and you get overwhelmed (r7)

When I was doing the degree course, my colleagues would ask me, which course are you doing? I told her I am doing a degree in midwifery, then they would ask me, are you going to deliver babies through the mouth? They would discourage me that there is nothing new I was learning - midwifery will stay midwifery. Such comments would make me doubt the importance of the degree at the start. Then, some of the doctors would ask me, are you able to carry out Caesarean sections? I would be scared to consult such a doctor - this would put me on tension in case I was working with this particular consultant on a patient fearing to make a mistake. I became resilient. Also, my supervisor informed my colleagues that having a more knowledgeable person in the unit improves performance. They have since appreciated me (r13).

Because of the work I have so I even spend less time at home. It is even less than when I was at the university because I have a lot of responsibilities now. Because I graduated and demonstrated better skills and performance, it has earned me more responsibilities (r3)

Five respondents mentioned that stress and work pressure was also aggravated by the need to earn more money to clear debts incurred through study. However, respondents also had a lot to say about what they had learnt during their studies about how to cope with stress. This included better communication skills for dealing with interpersonal relationships, acquisition of time management skills and stress-reduction techniques. Several also mentioned the importance of peer support among the graduate cohort, including the way their *WhatsApp* group had facilitated this.

The main reason my wellbeing has improved is because I can think deeper (r13).

When it comes to professional development with our cohort I have liked the way we support each other. When I have anything that concerns my profession or midwifery and I share it with any of them, they are really very supportive (r8).

I like sharing knowledge and colleagues who are studying normally consult me. Because I am more knowledgeable than some people I work with they appreciate my input... The reason for this is the training we went through at Aga Khan (r5).

I handle stress by being positive that it will soon end, opening up to a trusted friend indeed, timely accomplishment of duties, sharing with people who have gone through the same, praying over the situation and thinking that many have faced this and managed and hence I can. For anxiety I need to have self-confidence, be up-to-date most of the time to be able to consult. For me, a challenge is a step to a better landing (r1, WhatsApp transcript).

Raised career aspirations

All fourteen participants reported having higher aspirations for their careers, a greater commitment to moving forward in their profession and belief in the feasibility of doing so, subject to the challenge of securing finance for further study. In addition to building competence, confidence and resilience their responses indicate strong self-identification as members of a pioneering cohort of graduate midwives in Uganda. The role of AKU teaching staff as positive role models also emerged strongly.

There are many opportunities because I am among the few who have the degree in midwifery. After attaining my degree, I have chances to proceed and upgrade my career Very many opportunities but I put them on hold because of lack of funds. It's because I'm one of the few midwives at the hospital with a degree and highly skilled (r1).

I can say I expect more promotions. The reasons for the change is that I went back to school, got the competence, skills and knowledge. In addition, the support of the faculties to help us improve our careers and when I see them with their qualifications I feel that I should also be like them. Most of them had masters and PHD and I felt that I should be like them (r9).

I am planning to do more, I want to be a policy maker in midwifery. I want to become a midwifery consultant. If others can why not me? (r8).

I also feel blessed to be part of AKU family because they helped me fulfil my dream of attaining a bachelors' degree in midwifery. At first the public lacked confidence in the program but later on they are appreciating, even in the new structure of the public service we are included and my colleagues still at diploma level are consulting me of how we managed to get the bachelors (r2, WhatsApp transcript).

I am proud to be part of AKU. Many of my workmates wanted to join AKU but they didn't meet the entry criteria. This is because of what the products of AKU do better than they do. The doctors always encourage them to emulate us in the way we work – independent and evidence-based practice. We get both positive and negative comments from colleagues; there are those who say we are proud and over confident and those who say that we over give care to patients but this is good because it makes us exceptional midwives since we are giving evidence-based care (r5, WhatsApp transcript).

Discussion

First and foremost, the research revealed a broad range of positive changes in self-reported competence, confidence, wellbeing and career prospects of a pioneering cohort of bachelor's degree-level midwives in Uganda. An important general lesson that can be drawn is the importance of combining acquisition of *technical* knowledge and skills, with the *social* skills required both for leadership in the profession, and pursuit of careers in an often demanding working and living conditions. This included being able to manage resentment and jealousy among work colleagues, including midwives who feel threatened by their acquisition of a degree qualification. This concept resonates with White's (2018) emphasis on the importance of evaluating changes in wellbeing at the inter-subjective and relational level, as well as the individual level.

A second finding highlighted the dynamic process of formation and adjustment of aspirations for wellbeing experienced by students undergoing higher education and professional development. An accentuated gap between aspirations and satisfaction with their realisation is one way of defining wellbeing (Copestake and Camfield, 2010). There is a risk that raised standards and aspirations for professional practice can be counterproductive on professional practice if they prove unrealisable in the often isolated and resource poor working context they encounter after graduating. Associated negative emotions and demotivation can foster

defensive and even unprofessional conduct, including a failure to build respectful relationships with less qualified professional colleagues and clients. This can partly be offset by explicitly confronting this potential challenge in the training itself, including thorough discussion of possible coping strategies. In addition, motivation can be maintained by promoting a shared identity among the graduates and a culture of mutual support.

Third, the need for counselling training and competency development in the management of stress was also highlighted as an important consideration in Midwifery education and practice. This finding is consistent with existing literature highlighting the day-to-day challenges faced by midwives, particularly in LMIC's. Stresses include high workload, lack of support and inadequacy of supplies in day-to-day practice (Bremnes, Wiig, Abeid & Darj, 2018). Student midwives also experience and witness issues of trauma that require debrief and supportive counselling (Davis & Coldridge, 2015). This study revealed the use of whattsapp as a support mechanism while also identifying the need for stress management and supportive counselling as part of quality programme delivery.

Fourth, this was the first research study to employ the QuIP methodology to assess midwifery training and practice, incorporating wellbeing domains identified through research into wellbeing in developing country contexts (Gough and McGregor, 2007).

In the main, respondents provided overwhelmingly positive feedback. Responses were detailed, diverse and also made reference to important negative outcomes also, including enhanced professional jealously, debt and workloads. Particularly striking is the students' testimony of their enhanced resilience and willingness to respond to extra challenges. Being the subject of research - that itself facilitated individual and technology assisted peer group discussion and reflection - may also have contributed in a small way to this positive outlook. If so, then this provides further grounds for ensuring that technical aspects of graduate midwifery education are integrated with an emphasis on personal and social skills required to build strong professional relationships, including leadership roles.

Limitations

The research is limited by the fact that the research approach involves on approach only to the measurement and evaluation of programme impact. The sample represented only one cohort and this cohort was the first to complete the programme. Because the cohort was

small, participants may have been more hesitant to express negative views than if the evaluation was entirely independent.

Implications for Practice

The quality of higher education is enhanced by a commitment to continuous measurement, evaluation and feedback. Involving students in evaluative endeavours is an important component of this commitment (Horn & Dunagan 2018). This research was undertaken to gain insight into student's self-assessed changes in well-being as a consequence of programme completion and to enable the provider to consider what worked well within the programme and what could be improved in subsequent programme offerings. The research was also undertaken to provide pointers to other providers of similar programmes. In respect to implications for practice the research highlighted the beneficial involvement of both technical and soft-skills ~~inclusion~~ including skills in leadership and critical thinking. Findings also highlighted stress points with the programme and the need to ensure that counselling and other support services are available to participating students. The use of WhatsApp groupings including the student cohort alone plus student and faculty grouping was highlighted as an effective and affordable support provision.

Future Research

This research focussed on one aspect of evaluating an inaugural degree-level Midwifery programme in Uganda. There is scope further research, covering a longer time frame and a larger sample of midwives, to explore how far raised professional standards, personal motivation and peer support were sustained over time. Since the main focus of this study was on respondents' own perceptions on changes in their wellbeing and professional prospects there is also further scope to research how others stakeholders perceived them to have changed through their graduate training and after.

References

Braun, V., Clarke, V. (2006) Using thematic analysis in psychology. Qualitative Research in Psychology, 3 (2):77-1010.

Bremnes, H. S., Wiig, A. K., Abeid, M., & Darj, E. (2018). Challenges in day-to-day midwifery practice; a qualitative study from a regional referral hospital in Dar es Salaam, Tanzania. *Glob Health Action, 11*(1), 1453333. doi:10.1080/16549716.2018.1453333

Brownie, S., et al. (2018). "Assessing the impact of a partnership-based work/study nursing upgrade programme in a low- and middle-income setting." Journal of Clinical Nursing. In Press.

Copestake, J., Camfield, L. (2010) Measuring multidimensional aspiration gaps: a means to understanding cultural aspects of poverty. Development Policy Review, 28(5):617-633.

Copestake, J. (2014). "Credible impact evaluation in complex contexts: Confirmatory and exploratory approaches." Evaluation **20**(4): 412-427.

Copestake, J., et al. (2018). "Managing relationships in qualitative impact evaluation to improve development outcomes: QuIP choreography as a case study." Evaluation **24**(2): 169-184.

Copestake, J., Morsink, M., Remnant, F., editors (2019) *Attributing Development Impact: the Qualitative Impact Protocol Case Book*. Rugby: Practical Action.

Davies, S., & Coldridge, L. (2015). 'No Man′s Land': An exploration of the traumatic experiences of student midwives in practice. *Midwifery, 31*(9), 858-864. doi:https://doi.org/10.1016/j.midw.2015.05.001

Edwards, G., Hellen, K., & Brownie, S. (2018). Developing a work/study programme for midwifery education in East Africa. Midwifery, 59, 74-77.

Gough, I., McGregor, J. (2007) Wellbeing in developing countries: from theory to research. Cambridge: Cambridge University Press.

Horn, M. B., & Dunagan, A. (2018). Innovation and Quality Assurance in Higher Education. In S. D. Phillips & K. Kinser (Eds.), *Accreditation on the Edge: Challenging Quality Assurance in Higher Education*. USA: John Hopkins University Press.

ICM (2010). ICM Global Standards for Midwifery Education (2010 amended 2013). Available at: https://www.internationalmidwives.org/our-work/policy-and-practice/global-standards.html

Mager, F., et al. (2017). Cash Cropping and Care: How cash crop development is changing gender relations and unpaid care work in Oromia, Ethiopia. http://hdl.handle.net/10546/620392.

Martinez, E., et al. (2013). "Striving to Obtain a School-Work-Life Balance: The Full-Time Doctoral Student." International Journal of Doctoral Studies **8**.

Morsink, M., Copestake, J., Burke, E., Davies, G., Mukuru, M., with Mannino, C. (2019) Placing volunteer educators: the Global Health Service Partnership. In Copestake, J., Morsink, M., Remnant, F. (editors) *Attributing Development Impact: the Qualitative Impact Protocol Case Book*. Rugby: Practical Action.

Nabirye, R. C., Brown, K. C., Pryor, E. R., & Maples, E. H. (2011). Occupational stress, job satisfaction and job performance among hospital nurses in Kampala, Uganda. Journal of nursing management, 19(6), 760-768.

Remnant, F., Copestake, J. (2019) Qualitative Impact Protocol (QuIP) Guidelines. In Copestake, J., Morsink, M., Remnant, F. (editors) *Attributing Development Impact: the Qualitative Impact Protocol Case Book*. Rugby: Practical Action.

Sharma, G., et al. (2015). "Quality care during labour and birth: a multi-country analysis of health system bottlenecks and potential solutions. ." BMC Pregnancy and Childbirth **15**(2): S2.

Tearfund (2018) Flourishing churches, flourishing communities. Church and community mobilisation in Uganda. London: Tearfund. https://learn.tearfund.org/~/media/files/tilz/churches/ccm/2018-tearfund-flourishing-churches-flourishing-communities-ccm-in-uganda-en.pdf?la=en [accessed 25 Nov 2018]

The World Bank (2017). "Country focus-Uganda." Available at: https://data.worldbank.org/country/uganda.

UNFPA (2017). The State of The World's Midwifery: Analysis of the Sexual, Reproductive, Maternal, Newborn And Adolescent Health Workforce in East & Southern Africa South Africa**:** 108.

Wallace, J. (2016). "Nursing student work-study internship program: an academic partnership. ." Journal of Nursing Education **55**(6): 357-359.

White, S. (2018) Relational Wellbeing: Re-centring the Politics of Happiness, Policy and the Self. Policy and Politics. 45, 2:121-136

WHO. (1995). "WHOQOL: Measuring Quality of Life." Retrieved October 8, 2018, Available at: http://www.who.int/healthinfo/survey/whoqol-qualityoflife/en/.

WHO (2016). "Every woman every child global strategy." Available at: https://www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=1&cad=rja&uact=8&ved=2ahUKEwiI67CloeDeAhUFCSwKHWNpDDsQFjAAegQICRAB&url=http%3A%2F%2Fwww.everywomaneverychild.org%2Fglobal-strategy%2F&usg=AOvVaw3JKe1AXd4-yN_2YvxQabPX

WHO. (2018a). "World Health Statistics." Retrieved October 10, 2018, Available at: http://www.who.int/gho/publications/world_health_statistics/2018/EN_WHS2018_SDGhighlights.pdf?ua=1.

WHO. (2018b). "Global Health Observatory. Births by skilled birth attendant. Available at; http://www.who.int/gho/maternal_health/skilled_care/skilled_birth_attendance_text/en/